



Commonwealth of Kentucky
Environmental and Public Protection Cabinet

Office of Mine Safety and Licensing
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EMERGENCY AWARENESS BULLETIN

To: All District Supervisors, Inspectors, Analysts and Instructors

From: Ronald H. Hughes, Director
Division of Investigation

Date: February 17, 2006

EAB-06004 Kentucky Fatality # 3 (National #20) Roof Fall

At approximately 8:25 a.m., Eastern Standard Time on February 16, 2006, an underground roof bolter operator was fatally injured in an underground coal mine in the Hazard District. The victim was 33 years of age with 7 years of mining experience – 4 years at this mine and 4 years on this occupation.

This mine is a single unit mine and employs a total of 43 employees on two production shifts. This unit was in the process of moving from the first left area to the second left area of the 012 sub mains. The roof bolter operator (Victim) was helping two other coworkers in removing and relocating a permanent stopping from one location to another. The victim at the time of the accident was in the process of picking up the building material (concrete blocks) from the removed permanent stopping and loading it into the scoop when a piece of roof rock measuring approximately 14 feet in length, 3.5 feet in width and 1 to 9 inches in thickness fell and struck him on the head and shoulders. This fall occurred in the entry between the previously installed roof supports (48 inch resin roof bolts with a six inch plates).

The roof rock was removed from the victim by his coworkers and medical attention began immediately by trained mine emergency personnel. The victim was then prepared for transportation and transported to the surface area of the mine. Paramedics continued working with the victim and prepared him for transport to the Hazard Appalachian Regional Hospital where he was pronounced dead by the emergency room physician at 10:00 AM. This is the second roof fall fatality in Kentucky this year.

This accident is currently under investigation by the Office of Mine Safety and Licensing and the Mine Safety and Health Administration.

PREVENTATIVE MEASURES:

1. Since this accident occurred in an area where the roof had been previously supported and visually examined, it is recommended that the area (between bolt rows) where the permanent stopping or brattice had been standing and removed be examined by the sound and vibration method.

Remember, all accidents are preventable. We simply fail to prevent them.



COAL CORP.

H24 -
STATE FILE NO. XXX
FATAL ACCIDENT

FEBRUARY 16, 2008

SPAD NUMBER
11783

Coworker
- PREPARING
TO LOAD CONCRETE
BLOCKS INTO THE SCOOP
BUCKET

X

THIS SIDE OF THE
PERMANENT STOPPING WAS
PUSHED OUT FIRST

BOTTOM ROW OF
CONCRETE
BLOCKS

CONCRETE BLOCKS
THAT WERE PUSHED
OUT FROM THE
PERMANENT
STOPPING BY THE
SCOOP

Coworker

PREPARING TO
LOAD CONCRETE
BLOCKS INTO THE
SCOOP BUCKET

SCOOP BUCKET

15' 8"

27' 5"

27'

Coworker

SCOOP OPERATOR

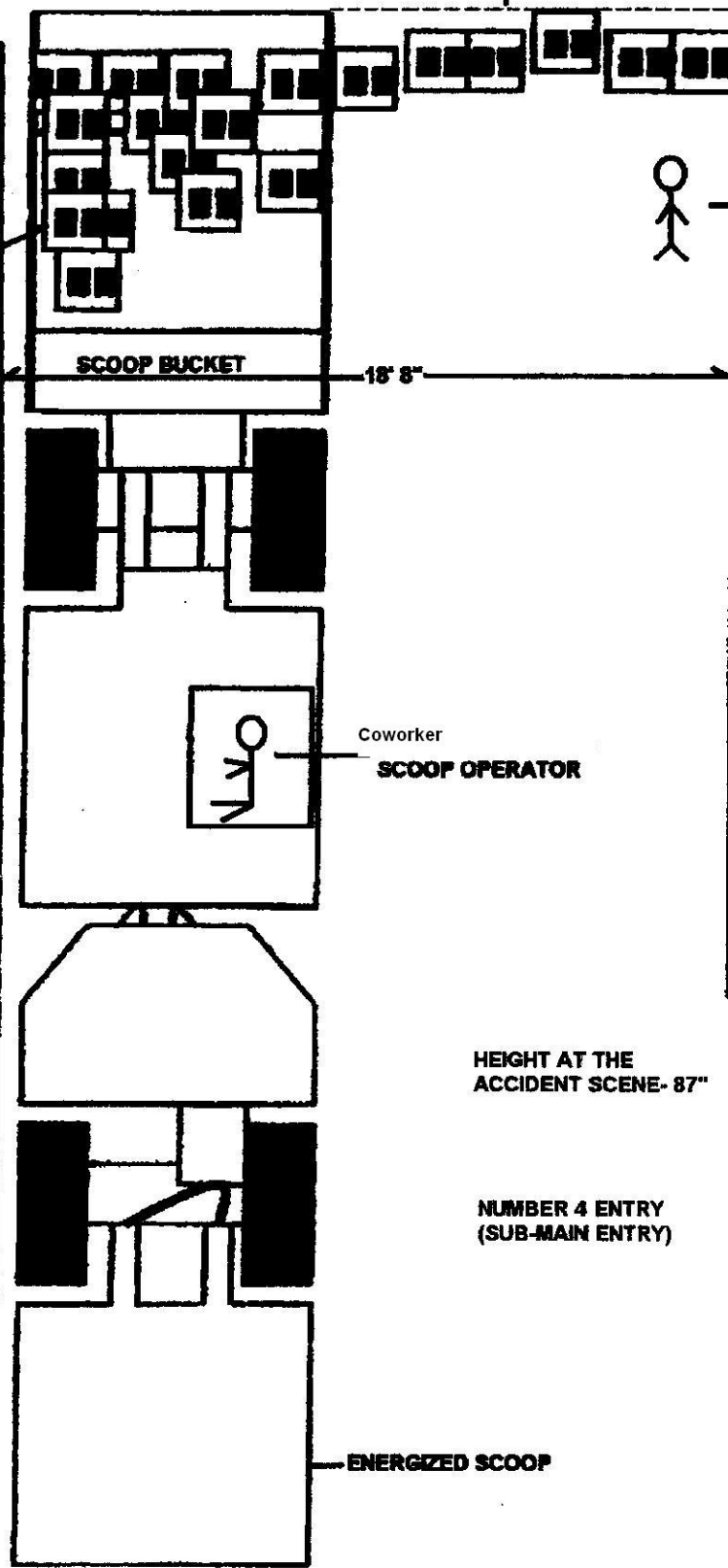
HEIGHT AT THE
ACCIDENT SCENE- 87"

NUMBER 4 ENTRY
(SUB-MAIN ENTRY)

SKETCH NO. 1
BEFORE THE
ACCIDENT

NOT TO
SCALE

ENERGIZED SCOOP



COAL CORP.

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X

